FORM 104

The Commonwealth of Massachusetts
Department of Industrial Accidents – Department 104
600 Washington Street – 7th Floor, Boston, Massachusetts 02111
Info. Line 800-323-3249 ext. 470 in Mass. Outside Mass. - 617-727-4900 ext. 470
http://www.mass.gov/dia

DIA Board # (If Known):

INSURER'S NOTIFICATION OF DENIAL

THIS FORM MUST BE FILED WITH THE DIA WHEN WEEKLY BENEFITS ARE DENIED TO A CLAIMANT. A COPY OF THIS FORM MUST ALSO BE SENT TO THE CLAIMANT BY CERTIFIED MAIL.

***IMPORTANT - INSTRUCTIONS ON THE REVERSE SIDE*- Please Print Legibly or Type - Unreadable forms will be returned.**

INSURER

1. Insurance Carrier's Name and Address:	2. Self-insured?: ☐ Yes ☐ No If Yes Please Give Self-insurer Number:
3. Name, Address and Board of Bar Overseers Number of Insurer's Attorney:	4. Telephone Number of Insurer's Attorney:
5. Claim Representative's Name:	6. Claim Representative's Tel. Number & Ext. :
7. Insurer's Case File Number:	8. Did Insurer Receive First Report of Injury (Form 101): ☐ Yes ☐ No - If Yes - Date Received (mm/dd/yyyy)

EMPLOYEE

9. Employee's Name (Last, First, MI):	10. Employee's Social Security Number*:
11. Employee's Address (No. and Street, City, State, Zip Code):	12. Date of Birth (mm/dd/yyyy):
13. Employer's Name:	
14. Employer's Address (No. and Street, City, State, Zip Code):	
15. Date of Alleged Injury (mm/dd/yyyy):	16. If Employee has Died, Date of Death (mm/dd/yyyy):

GROUNDS FOR DENIAL

17. Specify grounds for denial and give a brief statement of the specific facts supporting the grounds for denial. Failure to do so may cause loss of defenses under M.G.L. c 152, Sections 7(1) and 7(2).

A. ☐ No Personal Injury _____

B. ☐ No Injury Arising Out of and in the Course of Employment _____

C. ☐ No Disability _____

D. ☐ No Causal Relationship Between Personal Injury and Disability _____

G. ☐ Lack of Jurisdiction _____

X. ☐ Lack of Notice _____

Y. ☐ Late Claim _____

H. ☐ Other (Specify) _____

18. Insurer's Signature :	**19. Date Prepared (mm/dd/yyyy):**

***Disclosure of Social Security Number is Voluntary. It will aid in the processing of documents.**

An Employee/Claimant seeking to secure benefits must use Department of Industrial Accidents Form 110 when filing a claim.

INSURER'S NOTIFICATION OF DENIAL

FILING INSTRUCTIONS

1. WHEN TO FILE: File this form within 14 days of the Insurer's receipt of the Employer's First Report of Injury (Form 101) or a written claim for weekly benefits on a form prescribed by the Department (Form 110) pursuant to M.G.L. c. 152, §7(1).

2. WHERE TO FILE: This form should be mailed to the DIA at the address shown on the front of the form. Copies of this form must be provided to the Employer, and sent to the Employee via **certified mail**.